Supreme Court, U.S.
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No. 99-1083

IN THE
SUPREME COURT OF THE UNITED STATES

JEFFREY HULL,

Petitioner,

v.

RICHARD H. FALLON, M.D.
PRUDENTIAL HEALTHCARE SYSTEM, INC., et al.,

Respondents.

BRIEF *AMICI CURIAE* OF THE STATES OF MISSOURI, ARKANSAS, DELAWARE, ILLINOIS, IOWA, MARYLAND, MICHIGAN, MINNESOTA, MISSISSIPPI, NEVADA, NEW MEXICO, NORTH CAROLINA, NORTH DAKOTA, PUERTO RICO, RHODE ISLAND, TEXAS and UTAH IN SUPPORT OF PETITIONER'S PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether § 502(a) of ERISA completely preempts a patient's state medical malpractice claim against his managed care organization and its medical director when the claim is based on the medical director's decision to deny coverage for the treatment prescribed by the patient's treating physician because the medical director, after consulting with the patient's treating physician, concluded that the treatment was not "medically necessary."

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INTEREST OF AMICI CURIAE

Amici curiae, the undersigned Attorneys General of the States of Missouri, Arkansas, Delaware, Illinois, Iowa, Maryland, Michigan, Minnesota, Mississippi, Nevada, New Mexico, North Carolina, North Dakota, Puerto Rico, Rhode Island, Texas and Utah support the petition of Jeffrey Hull for a writ of certiorari. Like Hull, a substantial portion of the citizens in the *amici's* states receive health care through their employers' health plans provided by managed care organizations ("MCOs"). With regard to medical services provided by physicians, paid for by employers or otherwise, states use two tools to protect public health: the proactive tool of licensing, an effort to ensure that physicians have and maintain skills and knowledge; and the reactive tool of common law tort remedies, an effort to redress injuries caused by physicians' failure to properly apply their skills and knowledge. Those tools have been the province of state law and regulation for more than 150 years. *See, e.g.*, *Sutton v. Facey*, 1 Mich. 243, 1849 WL 1906, *4 (Mich. 1849) ("In most of the older states at an early period the statutes required that any one practicing as a physician should first obtain a license either from some state board of medical censors (as in Massachusetts, under the statute of 1818) or from some university or medical college (as in Alabama, under act of 1854)." Though the licensing requirement in Michigan was repealed in 1844, "every person assuming to practice was liable for damages in case of malpractice."). Given the dramatic expansion of managed care during the last decade, the question of the utility of those tools in the managed care environment is of vital interest to the *amici* states.

The U.S. Court of Appeals for the Eighth Circuit held that in the circumstances alleged here -- where a medical doctor acting as a prospective utilization reviewer (a

"physician-reviewer") for an MCO made a medical decision, *i.e.*, whether a particular treatment was medically necessary -- the state is preempted by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.*, from using tort law as a tool to protect its citizens. Such holdings have been asserted by physicians as defenses against actions against their licenses, on the premise that when a reviewer-physician decides what is "medically necessary," he is making an insurance coverage decision and not a medical decision. But actually, he is exercising his medical expertise while "consult[ing] with other physicians and surgeons." *Id.*[1]

Only the states in the Eighth Circuit are directly affected by that court of appeals' specific holding. But all states are affected by the confusion that it creates, both intrinsically, by confusing two different types of preemption, and extrinsically, for the Eighth Circuit holds that preemption is determined under a different, broader test than the ones used by other courts of appeals and by this Court. Assuming that under the Eighth Circuit's jurisprudence there is still a state role in determining how to relieve the ills caused by insurance company physicians who make medical decisions, the states cannot discern from existing caselaw where that role begins and ends. Indeed, the confusion and contradiction created by the varying statements of ERISA preemption in this area inhibit the states from addressing perceived problems in the provision of medical care, whether the proposed solutions come in the form of tort reform, licensing changes, or the creation of alternative remedies.

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[1] The States have also traditionally regulated the business of insurance. But unlike *UNUM Life Ins. Co. of Am. v. Ward*, 119 S.Ct. 1380, 1390-91 n. 7 (1999), this case does not involve ERISA's insurance savings clause.

That is one of the reasons that the Solicitor General was right when he recently told this Court that "questions regarding the scope of ERISA preemption of negligence claims against MCOs are currently of great nationwide importance." Brief for the United States as Amicus Curiae in *United States Healthcare Systems of Pa. v. Pennsylvania Hospital Ins. Co., petition for cert. filed*, No. 98-1836, at 6 ("*USHC*/US brief"). The issues of concern to the *amici* states cannot be resolved -- and thus the states' frustration cannot be addressed -- in either *United States Healthcare Systems* or *Pegram v. Herdrich, petition for cert. filed*, No. 98-1949.[2] Neither of those cases involves the ERISA provision at issue here, § 502(a). 29 U.S.C. § 1132(a) (1997). As the Solicitor General recently pointed out, again in his brief in *United States Healthcare*, "this Court has never delineated the boundaries of the preempted field in the context of health care benefits" under § 502(a). *USHC*/US brief at 15.

Moreover, in *United States Healthcare*, the Pennsylvania Supreme Court never suggested that the MCO exercised any medical judgment. The MCO said *where* the patient could be treated. Here, the MCO said *how*: through one type of medical test (determined by the physician-reviewer) rather than another (determined by the attending physician). The patient was told by the MCO physician-reviewer not just that a particular procedure was not covered, but that the procedure was not medically necessary. It is the

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[2] In addition to *United States Healthcare* and *Pegram*, the states' interest here is also similar to their interest in two tort preemption cases already on this Court's docket, *Geier v. American Honda Motor Co. Inc.*, No. 98-1811 (argued December 7, 1999), and *Norfolk Southern Rwy. Co. v. Shanklin*, No. 99-312 (to be argued March 1, 2000).

exercise of medical judgment by the physician-reviewer that makes this case of such great concern to the states as they pursue efforts to protect the public health.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case turns on interpretation and application of § 502(a), *not* of § 514 of ERISA. It addresses the meaning of the leading § 502(a) decision, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-67 (1987). There this Court announced that "causes of action within the scope of the civil enforcement provisions of § 502(a)" are removable to federal court and, once there, are completely preempted. *Id.* at 66. Simply stated, that is the test to determine if a given state law claim is completely preempted. But post-*Taylor* decisions by the lower courts have raised two distinct concerns. First, some circuit courts, including the Eighth Circuit Court of Appeals, have gone beyond *Taylor*, applying their own, broader tests to determine if a given state law claim is completely preempted. Second, even those circuits that have stayed within the framework set out by the statute and by *Taylor* have encountered great difficulty in defining exactly what state law claims fall "within the scope of the civil enforcement provisions of § 502(a)." Because of this confusion, some avenues of relief are open in one circuit and closed in another. Or to put it in the terms applicable to the *amici* states, some states can still regulate in some areas (or at least litigate that question in state court), while others cannot.

When relief in state courts and under state laws is improperly foreclosed, physician-reviewers and MCOs can make medical decisions without concern for tort liability. The health and welfare of MCO members are then compromised when MCOs pursue cost-cutting measures aimed at increasing profit. By issuing an opinion that

clarifies the precise scope of complete preemption, this Court can free the states either to retain and enforce existing protections for their citizens, or to search for new mechanisms that fall outside a more clearly defined preemption boundary.

ARGUMENT

I. This Court has recognized the confusion created by ERISA's dual preemption scheme and has differentiated between the tests to be used under that scheme.

Among the more complex and pervasive statutes in American history, ERISA has engendered significant litigation aimed at interpreting its provisions. Conspicuous among the causes of ERISA litigation are the law's two preemption provisions, §§ 502(a) and 514. 29 U.S.C. §§ 1132(a) and 1144(a). Those provisions invoke the two general types of state law preemption: complete preemption and conflict preemption. *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984). The more extraordinary type, complete preemption, results when Congress expressly occupies a particular field, thereby preempting any state law falling within that field. *Id.* That type of preemption is dealt with in § 502, at issue here. Conflict preemption occurs when a state law conflicts with federal law so as to preclude compliance with both state and federal law, or where state law prevents the accomplishment of Congress's purposes and objectives in creating the federal law. *Id.* That type of preemption is dealt with in § 514, not at issue here.

Unfortunately, the line between the two provisions and their proper applications is far from clear. Thus the confluence of those two provisions has combined with the general complexity of ERISA to create great confusion in

their application, a fact not lost on the courts of appeals. *E.g., Prudential Ins. Co. of Am. v. National Park Med. Center, Inc.*, 154 F.3d 812, 815 (8th Cir. 1998) ("The precise scope of ERISA preemption of state law has left courts, including the Supreme Court, deeply troubled."); *Heimann v. National Elevator Industry Pension Fund*, 187 F.3d 493, 499 (5th Cir. 1999) ("[C]onfusion arises in distinguishing between the 'complete preemption' . . . which creates federal removal jurisdiction and the more common ordinary preemption which does not.").

This Court is aware of this confusion and has repeatedly addressed specific areas of concern. *See California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316, 334-35 (1997) ("Since ERISA was enacted in 1974, this Court has accepted certiorari in, and decided, no less than 14 cases to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law. The rate of acceptance, moreover, has not diminished (we have taken two more ERISA pre-emption cases so far this Term), suggesting that our prior decisions have not succeeded in bringing clarity to the law."). Unfortunately the language Congress employed in drafting these provisions prevents simple resolutions. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). Nonetheless, this Court's opinions have provided a framework to aid the lower courts' interpretation of ERISA preemption.

That framework necessarily follows the statutory scheme, *i.e.*, it contemplates two types of preemption, with overlapping but not concurrent coverage. This Court endeavored to clarify the relative application of the ERISA preemption provisions in two opinions issued 13 years ago, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) and *Metropolitan Life Ins. Co. v. Taylor*. In *Pilot Life*, the Court

confirmed its prior opinions holding that § 514 conflict preemption swept expansively across a wide body of state law. 481 U.S. at 47. While in *Pilot Life* the Court discussed § 502(a) preemption as well, *Taylor* represents its primary interpretation of that provision. There the Court was faced with a situation much like Hull's: the petitioner had filed state law claims that were removed on the basis of federal question jurisdiction under § 502(a). 481 U.S. at 61. *Taylor* provided this Court's most cogent opinion to date distinguishing ERISA's preemption sections. Unfortunately, not just the complexity of ERISA, but the rapid changes in and increasing complexity of health care financing have lead to causes of action that evade proper resolution under *Taylor's* limited holding.

II. By going beyond the language of ERISA § 502(a) and the test defined for that section by this Court in *Metropolitan Life Ins. Co. v. Taylor*, the Eighth Circuit has increased the level of confusion and threatened to carry preemption well beyond the scope of the congressional mandate.

In *Taylor*, this Court began by acknowledging that standing alone, ERISA § 514 conflict preemption did not convert a state law claim into an action arising under federal law. *Id.* at 64. Rather, a state law claim may not be removed to federal court unless it falls within the scope of § 502(a)'s civil enforcement provisions. *Id.* at 66. While this decision clarified some issues, it left unanswered a litany of questions. Chief among them was the scope of § 502(a)'s civil enforcement provisions. *See Rice v. Panchal*, 65 F.3d 637, 641 (7th Cir. 1995) ("[T]he precise boundaries of § 502(a)'s complete preemption are not clear."). The opinion also created ambiguity regarding whether removal is proper without also finding § 514 conflict preemption. *See*

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 145 (1990). Courts of appeals for various circuits have resolved these questions with novel and inconsistent interpretations of *Taylor* and *Pilot Life*. The decision of the Eighth Circuit in this case is the most recent, and a very problematic contribution to that set of inconsistent interpretations.

Of course, there would be no federal jurisdiction over Hull's claims absent a finding that removal was proper under § 502. The Eighth Circuit, then, was obligated to begin by determining whether it had subject matter jurisdiction. *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1, 4 (1st Cir. 1999) ("A threshold matter in this case, as in every case, is subject matter jurisdiction."); *In re U.S. Healthcare, Inc.*, 193 F.3d 151, 158 (3rd Cir. 1999), *petition for cert. filed*, No. 98-1836. Because the absence of subject matter jurisdiction would preclude any findings on the merits, the logical course is to first examine § 502(a) complete preemption. *Danca*, 185 F.3d at 4. Thus, if federal court jurisdiction is asserted under § 502, the court must first determine whether the plaintiff's state law claim falls within the scope of that provision -- specifically, whether the claim is within the scope of § 502(a)'s civil enforcement provisions. *Taylor*, 481 U.S. at 66.

In deciding *Hull*, the Eighth Circuit began by acknowledging its obligation to first resolve the jurisdiction question. Unfortunately, the court then confused ERISA's preemption provisions. The Eighth Circuit began by referring to *Ingersoll-Rand Co. v. McClendon* for the proposition that ERISA's preemption clause is broadly worded to establish pension plan regulation as a federal concern. *Hull v. Fallon*, 188 F.3d 939, 942 (8th Cir. 1999). But in that portion of its opinion in *McClendon*, this Court was exploring the breadth not of § 502 or its civil enforcement provisions, but of § 514 conflict preemption. Nothing in *McClendon* suggests that its

discussion of § 514 should guide the lower courts in deciding whether claims brought up on removal are within the scope of § 502(a)'s civil enforcement provisions. *See McClendon*, 498 U.S. at 137-38.

The Eighth Circuit's purpose in examining § 514's preemptive breadth became evident when it announced its new test for finding complete preemption and removal jurisdiction. The Eighth Circuit held that "[c]auses of action within the scope of, *or that relate to*, the civil enforcement provisions of 502(a) are removable to federal court despite the fact the claims are couched in terms of state law." *Hull*, 188 F.3d at 942 (emphasis added). Adding the words, "or that relate to," the Eighth Circuit's test amounts to an indelicate merger of § 502(a)'s complete preemption analysis (which does not include the "relate to" language) and § 514's conflict preemption standard (which does). Such a merger is a departure from the language of the statute and from the holding in *Taylor* -- a departure that increases confusion as to ERISA preemption, reduces the ability of the states to protect the health and welfare of their citizens, goes beyond the scope of preemption expressly mandated by Congress, and merits this Court's review.

III. This Court's voice is required to silence the cacophony of disparate circuit court decisions interpreting, applying, and often confusing, the two forms of ERISA preemption.

The Eighth Circuit's confusion of § 502(a) and § 514 is symptomatic of the greater problem with applying ERISA's preemption provisions, especially in the context of medical decisions of the sort usually subject to state, rather than federal regulation. The test in the statute, reiterated but

perhaps not explained with enough detail in *Taylor*, has proven to be a source of great inconsistency and confusion.

Though the ultimate question must be "what claims fall within the scope of § 502(a)'s civil enforcement provisions?" (*Taylor*, 481 U.S. at 66), the lower federal courts have posed that question in varying forms and have defined disparate tests for answering it -- leading to inconsistent results. Thus each case begins when a plaintiff has filed a state law claim in state court against an entity purporting to be protected by ERISA's provisions. Then the defendant removes the matter to federal court. But the next step varies according to the circuit. In fact, in two circuits, different panels have taken different approaches.

One is the Seventh Circuit. The second case there is the one most factually similar to *Hull - Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996). There an ERISA plan participant brought a state law negligence claim against the utilization reviewer and the MCO that serviced the plaintiff's ERISA plan, alleging negligence in the utilization reviewer's decision to deny certain post-surgery physical therapy on the basis that it was not medically necessary. The Seventh Circuit looked at three factors to determine whether the plaintiff's claim was completely preempted:

> (1) whether the plaintiff is eligible to bring a claim under ERISA § 502(a);
>
> (2) whether the plaintiff's cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a); and

> (3) whether the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by federal law.

Id. at 1487. As in *Hull*, the Seventh Circuit found complete preemption. But though the outcome was the same, the test was markedly different: Nothing in the *Jass* test suggests that the Seventh Circuit would find that state law claims are preempted merely because they "relate to," rather than "fall within the scope of," § 502(a)'s civil enforcement provisions.

In a prior case, the Seventh Circuit used a different test -- though still one that does not read "relate to" into the statute. In *Rice v. Panchal*, 65 F.3d 637, 641 (7th Cir. 1995), the court of appeals explored in depth the differences between ERISA's preemption provisions. 65 F.3d at 639-641. Though the court considered all the issues discussed in *Jass* (*id.* at 641-644), the test it applied in *Rice* consisted of only the third *Jass* factor (*id.* at 644-646 ("Rice's claim . . . does not rest upon the terms of an ERISA plan, and it can be resolved without interpreting an ERISA plan. Therefore, his claim is not properly recharacterized . . . .")). Because nothing in *Jass* addresses the change from *Rice*, Seventh Circuit litigants are left confused as to the meaning of the other *Jass* factors.

Varying decisions in the Second Circuit create similar confusion. In *Lupo v. Human Affairs International, Inc.*, the court of appeals interpreted *Taylor* narrowly by considering whether Lupo's state law claims could literally be recharacterized as § 502(a) civil enforcement actions. 28 F.3d 269, 272 (2nd Cir. 1994) ("On their face, none of these claims bears any significant resemblance to those

described in § 1132(a)(1)(B)."). Consequently, the court remanded Lupo's state law claims to the district court with instructions to remand them to the state court. But just nine months later, the same circuit applied a different test to determine whether a state law claim was properly removed to federal court under § 502(a) complete preemption. *Franklin H. Williams Ins. Trust v. Travelers Ins. Co.*, 50 F.3d 144, 149 (2nd Cir. 1995). In *Williams Trust*, the court purported to follow *Taylor* in announcing that the test for removal was whether the state law claim (1) relates to an ERISA plan within the meaning of § 514, and (2) falls within the scope of ERISA's civil enforcement provisions in § 502(a). *Id.* The particular error committed in *Franklin* is often repeated. *See Custer v. Sweeney*, 89 F.3d 1156, 1165 (4th Cir. 1996); *Heimann v. National Elevator Industry Pension Fund*, 187 F.3d 502; *Emard v. Hughes Aircraft Co.*, 153 F.3d 949, 953 (9th Cir. 1998); *Carland v. Metropolitan Life Ins. Co.*, 935 F.2d 1114, 1119 (10th Cir. 1991).

One group of circuits -- the Third, Sixth, and Ninth -- has not only avoided internal conflicts, but seems to have reached a near consensus. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 355-56 (3rd Cir. 1995); *Warner v. Ford Motor Co.*, 46 F.3d 531, 534 (6th Cir. 1995); *Toumajian v. Frailey*, 135 F.3d 648, 655 (9th Cir. 1998). *Cf. Emard*, 153 F.3d at 953. These courts have applied § 502(a) preemption narrowly, demonstrating reluctance to indiscriminately apply the extraordinary preemptive force that accompanies complete preemption. In doing so, these courts have simply asked whether the state law claims seek the same relief available under § 502(a). *See, e.g., Dukes*, 57 F.3d at 356 ("The plaintiffs here simply do not claim that the plans erroneously withheld benefits due. Nor do they ask the state courts to enforce their rights under the terms of their respective plans or to clarify their rights to future benefits.").

None of those holdings are compatible with the Eighth Circuit's insertion of "relate to" into § 502.

The First Circuit asks a question that amounts to a similar standard, though it could be read more broadly than the questions posed in the Third, Sixth, and Ninth Circuits. In *Danca v. Private Health Care Systems, Inc.*, the court held that a state cause of action is within § 502(a)'s scope when the state law "can be properly characterized as an 'alternative enforcement mechanism' of ERISA § 502(a) or of the terms of an ERISA plan." 185 F.3d at 5. But even that conclusion is not as broad as the one reached by the Eighth Circuit.

The Eleventh Circuit appears to apply the proper standard, despite failing to identify the correct test from *Taylor*. In *Whitt v. Sherman International Corp.*, the court simply held that state law claims seeking relief available under ERISA are recharacterized as ERISA claims and therefore arise under federal law. 147 F.3d 1325, 1329 (11th Cir. 1998). This evolutionary step may be supported by the observation in *Taylor*, quoting § 502(f), that "the district courts . . . shall have jurisdiction . . . to grant the relief provided for in subsection (a) of this section in any action." 481 U.S. at 65. But like the holdings in the First, Second, Third, Sixth, Seventh, and Ninth Circuits, it does not go as far as the Eighth Circuit demands.[3]

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[3] By contrast, the D.C. Circuit may have gone beyond the Eighth Circuit. *Board of Trustees of the Hotel and Restaurant Employees Local 25 v. Madison Hotel, Inc.*, 97 F.3d 1479, 1484 (D.C. Cir. 1996) ("[A] state-law based complaint which 'relate[s] to [an] employee benefit plan' under section 514(a) of ERISA . . . such that the complaint is preempted by ERISA, is 'necessarily federal in character by virtue of the clearly manifested intent of Congress,' and therefore 'arise[s] under the laws . . . of the United States' for

Perhaps the internal differences in and among the circuits are caused in part by the mixed signals some might see in this Court's decision in *Taylor*. At one point, the Court suggested that removal under § 502 could only occur if the claim was also conflict preempted under § 514, *i.e.* the claim "related to" an ERISA plan. 481 U.S. at 64, *citing Franchise Tax Bd. of Calif. v. Construction Laborers Vacation Tr. for S. Calif.*, 463 U.S. 1, 25-27 (1983). Ultimately, this Court chose not to take a step down that road, holding instead that ERISA complete preemption applied simply to "causes of action within the scope of the civil enforcement provisions of § 502(a)." 481 U.S. at 66. Nonetheless, the absence of any definition of the "causes of action within the scope of the civil enforcement provisions of § 502(a)" has left plenty of room for variation.

Whether state law claims like Hull's are completely preempted or remain viable and must be remanded to state court is a question that arises more and more often as managed care continues to expand through the American health care system. And the answer will vary according to which state has jurisdiction -- one in the Eighth, or one a circuit that has drawn ERISA preemption more narrowly. That variability will continue, and its significance will grow, absent a definitive holding as to whether the apparently common facts stated here state a "cause[] of action within the scope of the civil enforcement provisions of § 502(a)" (481 U.S. at 66).

CONCLUSION

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purposes of original federal subject matter jurisdiction under 28 U.S.C. § 1331 (1994)."). Certainly that court's approach is different than the more limited one used in the other circuits discussed.

Though ERISA § 502(a) may be the exclusive remedy for rights guaranteed under ERISA, no provision in ERISA safeguards plan participants' right to quality medical care. This Court should hear this case to decide whether, and to what extent, the states have a role in safeguarding patients against MCO physician-reviewers who overrule a treating physician's conclusion that a particular procedure is not "medically necessary."

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